(1)

Approval:
Arlene Groff
(signature)
Date: 2/16/05

DATE: 1-17-05

TO: Laura Patrick

Social Security Number 025-52-1378

Address 5 Emerald Ave
Marblehead, MA 01945

Phone Number (781) 639-0902

Department Design

FROM: Janssen company/location
Pamela Greene employer representative

EXHIBIT
Patrick 1
SLP 1/25/05

SUBJECT: **FAMILY AND MEDICAL LEAVE**
- ☐ New Leave of Absence
- ☐ Extension of Previous Leave
- ☐ Revision of Previous Leave

I. On 12-22-04 (date) you notified us of your needs to take family/medical leave due to:

(a) ☐ The birth of your child, or the placement of a child with you for adoption or foster care. Date of birth, adoption or placement of foster care anticipated to occur on _____ (date); or

(b) ☑ A serious health condition that makes you unable to perform the essential functions of your job; or

(c) ☐ A serious health condition affecting your ☐ spouse, ☐ child, ☐ parent, for which you are needed to provide care.

II. You notified us that:

(a) ☐ You need this leave to begin on _____ (start date) continuing until _____ (end date) (Returning the following day).

(b) ☑ You project that this leave will begin on 1-17-05 (start date) and continue for 2-16-05 (end date) 4-6 weeks after the actual commencement date. weeks

(c) ☐ This leave is for recurring medical treatments on the dates ☐ identified on the attached schedule or ☐ to be determined.

(d) ☐ This leave is for intermittent leave with dates ☐ identified on the attached schedule or ☐ to be determined.

III. 1-14-00 (*last day of work*) is scheduled to be / was your last day of work

IV. You understand and agree that:

(a) If you are eligible under the FMLA you have a right under the FMLA for up to a total of 12 weeks of leave in a 12-month period for the reasons listed above. Health and Dental benefits will be maintained by the company during any period of unpaid leave under the same conditions as if you continued to work, and you will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you will be required to reimburse the company for its share of the costs of health and dental coverage paid on your behalf during your FMLA leave.

(b) You agree that when your leave is over, you will return to work at the same status as when you began the leave unless your supervisor has given written approval of a requested status change prior to your return from leave.

(c) You certify that the requested duration of this leave and all other leaves during the current leave year will not exceed a total of 12 weeks.

V. This is to inform you that:

(a) You **WILL** be required to furnish medical certification of a serious health condition by 1-30-00 (*insert date – must be at least 15 days after you are notified of this requirement)* or we may delay the commencement of your leave until the certification is submitted.

(b) The requested leave will be counted against your annual FMLA leave entitlement.

(c) You ☐ **HAVE ELECTED** or ☑ **WE HAVE REQUIRED** that you substitute accrued paid leave for unpaid FMLA leave as set out below. ☐ **NOT APPLICABLE** (*explain)*

(d) Paid Benefits Taken During Leave designate type as Vacation (V); Personal Leave (P) and Sick (S)

Total Paid Benefits Available: V 120 P _____ S 80

		Payroll End	# of Hours / Type			Payroll End	# of Hours / Type
Week	1	1-19-00	24hrs Sick	Week	7		
Week	2	1-26-00	4 hrs sick	Week	8		
Week	3	2-2-00	16 S - 24 V	Week	9		
Week	4	2-9-00	40 V	Week	10		
Week	5	2-16-00	40V	Week	11		
Week	6			Week	12		

(e) Although you will not lose benefit credits attained prior to the start of your leave, additional benefits will not accrue during any leave lasting longer than 4 work weeks after any paid time off.

(f) You presently have ☐ **SINGLE** ☐ **FAMILY** ☐ **NO** health coverage and ☐ **SINGLE** ☐ **FAMILY** ☐ **NO** dental coverage. Arrangements for payment have been discussed with you and you agree that you will make premium payments within one (1) pay period of commencement of leave of absence. You will receive an initial schedule of premiums due and you will receive bi-weekly billing from that point forward.

(g) You must pay your portion of the cost for health and dental coverage for each pay period you are on FMLA qualified leave. You may also elect to prepay your health and dental premiums before beginning your FMLA qualified leave.

☐ **PREPAY PREMIUMS**
☐ **HEALTH PREMIUM $**_____
☐ **DENTAL PREMIUM $**_____

(h) You have a 30-day grace period in which to make payments for group health and dental benefits. If payment is not made timely, your group health and dental coverage will be canceled, provided we notify you in writing at least 15 days before the date that your health and dental coverage will lapse.

(i) You ☐ **WILL** ☑ **WILL NOT** be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until the certification is provided.

(j) While on leave, you ☐ **WILL** ☑ **WILL NOT** be required to furnish us with periodic reports every _____ (*indicate interval of periodic reports, as appropriate for the particular leave situation*) of your status and intent to return to work. If the circumstances of your leave change and you are able to return to work earlier than the date indicated previously on this form, you ☐ **WILL** ☐ **WILL NOT** be required to notify us at least two (2) work days prior to the date you intend to report to work and obtain management approval to return early.

(k) You ☐ **WILL** ☑ **WILL NOT** be required to furnish medical recertification relating to a serious health condition every 30 days.

1 copy to employee / 1 copy to Taylor Corporation payroll / 1 copy to personnel file

FMLA WORKSHEET FOR EMPLOYER REPRESENTATIVE

(For Internal Use Only; Must be Attached to the Payroll and File Copies of the LOA Paperwork)

/ee Name: Laura Patrick
1-17-00

Employer Representative Name

Be Eligible For FMLA. The Following Must Apply:

- ☐ There are at least 50 employees in our facility or within 75 miles of our facility
- ☑ The Employee has been employed for at least 1 year
  - ☐ Employees Hire Date: 8-1-94
- ☐ The Employee has worked at least 1250 hours during previous 12 months
  - ☐ Number of Hours Employee Has Worked During Previous 12 Months 2080
- ☐ Has Employee had a previous FMLA leave in current calendar year?
  - ☐ If Yes, list dates: _____
    12 weeks - _____weeks taken = _____ weeks available
    (should not exceed 12 weeks in current calendar year)
- ☐ The reason for leave must be one of the following:
  - ☐ Birth or placement for adoption or foster care of a child; or
  - ☐ The *serious* health condition of a spouse, child or parent; or
  - ☐ Employee's own *serious* health condition. (*Serious* means a condition requires inpatient care or ongoing treatment)

Calculate the Total Leave Time

Employee **Pay Type**: ☑ Salary ☐ Hourly **Status**: ☐ FT ☐ PT ☐ Other – Specify_____

The Employee's regular weekly work schedule = 1 week

To determine any partial weeks:
hours not working in week ÷ hours regularly worked in a week = partial week gone

Total number of weeks scheduled to be out on leave 4.60

Number of weeks gone with pay 4.60
total number of benefit hours ÷ 40 for FT or 25 for PT = weeks gone with pay

Number of weeks gone without pay _____
total weeks in the leave - weeks gone with pay = weeks gone without pay

If the total number of weeks gone without pay is over **4 Weeks** Employee's start date will be adjusted

To calculate adjusted start date:

*Number of weeks gone without pay*_____ x 7 = _____*days to adjust the start date* (drop all fractions)

Inform employee that this adjusted date of hire will affect their review date, service award anniversary date, and may affect vacations and other benefits.

ealth and/or Dental Coverage?

During the 12 weeks of FMLA leave, the employee may maintain health and dental coverage by paying the employee portion of the premium. The Taylor Health and Dental Plan will bill the employee directly.

781 849 8322
FAX - ATTENTION PAMELA
Call First
781-899-6300
888-526-776

Certification of Health Care Provider
(Family and Medical Leave Act of 1993)

1. Employee's Name:

2. Patient's Name (if different from employee): Laura Patrick

3. The definition of a "serious health condition" under the Family and Medical Leave Act is set forth on the back of this form. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category. (See reverse for explanation)

(1) ✓ (2)___ (3)___ (4)___ (5)___ (6)___ , or None of the above ____

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

Underwent major surgery (abdominal myomectomy) on 1/17/2000

5.a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity[2] if different):

6 week recovery period

b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)? ____

If yes, give the probable duration: 6 week recovery

c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated[2] and the likely duration and frequency of episodes of incapacity[2]:

6.a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

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[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

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1 copy to employee / 1 copy to Taylor Corporation payroll / original to personnel file

7.a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? yes

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)?____ If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? 6 week recovery

8.a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?____

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?____

If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

Mitchell Rem MD — Gynecology
(Signature of Health Care Provider) (Type of Practice)

1 Hutchinson Dr. Danvers MA 01923 — 978-777-1070 — 1/17/00
(Address) (Telephone number) (Date)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____ _____
(Employee signature) (Date)

_____
(Print Name)